

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fickman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fickman</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>BREEDING</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Breeding</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Calloway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Addie Breeding</u>		Address <u>Denton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Atherosclerosis</u> DUE TO cause last. (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>24 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAWSON O. GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Concord</u>		22d. LOCATION (City, town, or county) (State) <u>Concord, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Morrison, Denton</u>		24a. REC'D BY REGISTRAR <u>10/10/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. D. George</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. The funeral director must file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

OCT 15 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10-48 CERTIFICATE OF DEATH

10134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston			c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Emory Brodes				4. DATE OF DEATH Month Day Year October 13 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1897		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roller Rink Owner		10b. KIND OF BUSINESS OR INDUSTRY Skating Rink		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John E. Brodes				14. MOTHER'S MAIDEN NAME Edith Bryan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-6977		17. INFORMANT Address Mrs. Elma T. Brodes, Preston, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lung Left DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mos 12 ms		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>12/12</u> 19 <u>55</u> to <u>October 13</u> 19 <u>56</u> that I last saw the deceased alive on <u>10/14</u> 19 <u>56</u> and that death occurred at <u>1:20 AM</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Harold B. Plummer</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Preston, Maryland</u> <u>10/13/56</u>				
PHYSICIAN'S NAME (Type) Harold B. Plummer, M.D.				Preston, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 1956		22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		22d. LOCATION (City, town, or county) (State) Linchester, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE <u>10-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Cornelia D. Plummer</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - HALLMARK 10

BUREAU V. 8

OCT 17 1956

RECEIVED

10149

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson	
c. LENGTH OF STAY IN 1b 50 Yrs.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None	
d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Brown Last Brown		4. DATE OF DEATH Month 10 Day 7 Year 19 56	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 56 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Brown	
14. MOTHER'S MAIDEN NAME Annie Mason		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Blanche Locke Henderson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 10 19 56 , to Oct. 7 , 19 56 , that I last saw the deceased alive on Oct. 6 , 19 56 , and that death occurred at 3A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 10/8/56			
ACTUAL SIGNATURE Charles H. Stonesifer M.D.		22. NAME OF CEMETERY OR CREMATORY Union	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer		22d. LOCATION (City, town, or county) (State) Goldsboro. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/56	22c. NAME OF CEMETERY OR CREMATORY Union	22d. LOCATION (City, town, or county) (State) Goldsboro. Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie		24a. REC'D BY REGISTRAR DATE 10/12/56	
ADDRESS Greensboro Md.		24b. REGISTRAR'S SIGNATURE A. C. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, with the registrars, should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 17 1956

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INSTRUCTIONS

ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10150

CERTIFICATE OF DEATH

10136

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Ind</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>	LENGTH OF STAY (in this place) <i>10 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>	TOWN <i>Denton</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>(First) Margaret (Middle) Chase (Last)</i>		<i>Month</i> <i>Oct</i> <i>(Day)</i> <i>5</i> <i>(Year)</i> <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct 13, 1864</i>
9. AGE last birthday <i>92</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Carroll Land</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>Samuel Hutchins</i>	
14. MOTHER'S MAIDEN NAME <i>Rachel Shepherd</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Crayson Taylor, Denton, Ind.</i>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>	
ANTECEDENT CAUSE(S) DUE TO		Hypertension	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		arteriosclerosis	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sept 19, 1956</i> to <i>Oct 5, 1956</i>, that I last saw the deceased alive on <i>Oct 5, 1956</i>, and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>H. L. Small</i>		DATE SIGNED <i>Oct 8, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Oct 9, 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Spring Grove</i>		LOCATION (City, town, or county) (State) <i>Denton, Ind.</i>	
24. REC'D BY REGISTRAR <i>10-9-56</i>		REGISTRAR'S SIGNATURE <i>Wm D O George</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Knepper</i>		ADDRESS <i>Denton</i>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

GRANDPARENTS

GRANDFATHER

GRANDMOTHER

GRANDSISTER

GRANDBROTHER

GRANDNephew

GRANDNiece

GRANDSON

GRANDDAUGHTER

GRANDCHILD

GRANDCHILDREN

GRANDCHILDREN

BUREAU V. S.

OCT 13 1956

RECEIVED

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INVESTIGATION

ADDITIONAL INFORMATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10151

CERTIFICATE OF DEATH

10137

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston Harmony</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Preston Harmony</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>SAM</u> First <u>SLIP</u> Middle <u>DELOATCH</u> Last		4. DATE OF DEATH <u>Oct.</u> Month <u>7</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John D. DeLoatch</u>		14. MOTHER'S MAIDEN NAME <u>Rosa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Richard D. DeLoatch</u> Address <u>2704 Markham St. Portsmouth, Va.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory and stenosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syphilis -</u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>20 years.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 9</u> , 19 <u>54</u> , to <u>Oct 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>56</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D.		ADDRESS (Street, city or town, state) <u>Debtton Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts</u> M.D.		<u>Debtton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Harmony Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Kooner</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>10/11/56</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		<u> </u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. E.

OCT 13 1956

RECEIVED

10152

CERTIFICATE OF DEATH

Reg. Dist. No.

10138

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		c. LENGTH OF STAY IN 1b 14 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jonestown	
d. STREET ADDRESS Jonestown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Timothy Middle M. Last Farmer		4. DATE OF DEATH Month October Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1896
9. AGE (in years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church of God in Christ	
11. BIRTHPLACE (State or foreign country) Louisville, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alex Farmer		14. MOTHER'S MAIDEN NAME Frances (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 260-05-1368	17. INFORMANT Mrs. Willie Farmer, Preston, Md., R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart Disease DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/20/43 , 19____, to 10/28/56 , 19____, that I last saw the deceased alive on 10/28/56 , 19____, and that death occurred on 10/28/56 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold B. Plummer</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Preston, Maryland 10/1/56</i>	
PHYSICIAN'S NAME (Type) Harold B. Plummer, M.D.		Preston, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Church of God in Christ	22d. LOCATION (City, town, or county) (State) Near Preston, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 11/56	24b. REGISTRAR'S SIGNATURE <i>Cornelia N. Plummer</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. Filled in by the funeral director, who should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRAR: After this certificate has been signed by the attending physician and completed, the registrar should be detached for use as the burial transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

10153

CERTIFICATE OF DEATH

Reg. Dist. No.

66

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>				c. LENGTH OF STAY IN 1b <u>11 Yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>				d. STREET ADDRESS <u>None</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johns Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie</u> <u>Johnson</u>				4. DATE OF DEATH Month Day Year <u>10</u> <u>6</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>77-23-93</u>	9. AGE (In years last birthday) yn. <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No Record</u>			14. MOTHER'S MAIDEN NAME <u>No Record</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Johns Nursing Home Ridgely, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute perforated appendix with peritonitis</u> DUE TO <u>5501</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Terminal intestinal obstruction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>56</u> , to <u>Oct. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>10/9/56</u> ACTUAL SIGNATURE <u>Charles H. Stovesifer</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles H. Stovesifer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/8/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>University Medical School Baltimore, Md.</u>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boudreau Greensboro, Md.</u>		ADDRESS <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10-10-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Laird</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

RECEIVED

• OCT 13 1956

BUREAU V. 2

10154

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Henderson</u>				c. LENGTH OF STAY IN 1b <u>11 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Marion</u> Last <u>Kotowski</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Marine Surveyor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Africa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lenord Kotowski</u>				14. MOTHER'S MAIDEN NAME <u>Louise Kotowski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1908 to 1911</u>				16. SOCIAL SECURITY NO. <u>094-14-2857</u>		17. INFORMANT <u>Edith Kotowski</u> Address <u>Henderson, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MY HEART HAD A BREAKDOWN</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRRHOSIS</u> (c) <u>6 Mos</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 30</u> , 19 <u>56</u> , to <u>Oct 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>56</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John J. Smith</u> M.D.				DATE SIGNED <u>10-11-56</u>			
PHYSICIAN'S NAME (Type) <u>Robert H. Wright, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boone, Jr.</u> ADDRESS <u>Greensboro Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>A. A. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, may be required by the hospital or attending physician. Then please remove carbon papers and attach to the certificate. The certificate should be detached for use as the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10155
CERTIFICATE OF DEATH

10141

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 37 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Holt Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg, Md.	
		d. STREET ADDRESS Holt St.	
3. NAME OF DECEASED (Type or print) Hattie E. Liden		4. DATE OF DEATH Month Oct. Day 21 Year 1956	
5. SEX fem.	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1879
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Caleb Todd		14. MOTHER'S MAIDEN NAME Charlotte Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Viola Robinson		Address Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per life for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) inanition, Dehydration + Acidosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute Enteritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arteriosclerosis + Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 7 , 19 56 , to Oct. 21 , 19 56 , that I last saw the deceased alive on Oct. 20 , 19 56 , and that death occurred at Md. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Harrison		M.D. Hurlbuck, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Oct. 25, 1956	
22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		22d. LOCATION (City, town, or county) (State) near Federalsburg	
23. FUNERAL DIRECTOR'S SIGNATURE James W. Harrison		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR DATE 24 25 1956		24b. REGISTRAR'S SIGNATURE Margaret H. Frampton	

BUREAU V. S.

OCT 21 1956

RECEIVED

10156

CERTIFICATE OF DEATH

Reg. Dist. No. 41

10142

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Susie Middle M. Last Pimm		4. DATE OF DEATH Month 10 Day 24 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1864
9. AGE (In years last birthday) 91 yrs		IF UNDER 1 YEAR Months 9 Days 1 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New Jersey
13. FATHER'S NAME Alfred Meeker		14. MOTHER'S MAIDEN NAME Mary Sober	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Walter B. Pimm Greensboro, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebric following Bt. Hemiplegia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904 (b) of Cerebral Hemiplegia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Fracture Rt. Femur 7-24-56			INTERVAL BETWEEN ONSET AND DEATH 2 MOS 3 MOS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-24 1956 , to 10-24 1956 , that I last saw the deceased alive on 10-23 1956 , and that death occurred at 5 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert H. Wright M.D.		ADDRESS (Street, city or town, state) Greensboro Md DATE SIGNED 10-25-56	
PHYSICIAN'S NAME (Type) ROBERT H. WRIGHT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/26/56	22c. NAME OF CEMETERY OR CREMATORY Rosedale	22d. LOCATION (City, town, or county) (State) Orange, N. J.
23. FUNERAL DIRECTOR'S SIGNATURE F. E. Boulaie		ADDRESS Greensboro Md.	24a. REC'D BY REGISTRAR DATE 10/24/56
		24b. REGISTRAR'S SIGNATURE L. M. Lippin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

NOV 9 1950



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10143

10157

CERTIFICATE OF DEATH

Reg. Dist. No.

60

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Goldsboro</u>				c. LENGTH OF STAY IN 1b <u>26 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) <u>Walter</u> <u>Ross</u>				4. DATE OF DEATH <u>10</u> <u>11</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1905</u>	9. AGE (In years last birthday) <u>51</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Ross</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Sparks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-18-4803</u>		17. INFORMANT <u>Mammie Ross Goldsboro, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular</u> DUE TO (c) <u>Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 25</u> , 19 <u>55</u> , to <u>Oct. 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 11</u> , 19 <u>56</u> , and that death occurred at <u>10:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Storozifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Goldsboro, Md.</u> DATE SIGNED <u>Oct. 13, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Storozifer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Near Goldsboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Brown</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>AC Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 12 1956

10'58

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH a. COUNTY <i>Caroline</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	
c. LENGTH OF STAY IN 1b <i>5 yrs</i>		d. STREET ADDRESS <i>Denton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>NINA CHESTER RYAN</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>12</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 9, 1876</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown J Lynn</i>		14. MOTHER'S MAIDEN NAME <i>Emma Morgan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>4201</i>	
17. INFORMANT <i>Paul Knotts</i>		Address <i>Denton, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac (Coronary) infarction</i> DUE TO (b) <i>Coronary arterio sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>2 wks +</i> <i>3 years +</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Oct. 11, 1956</i> to <i>Oct 11, 1956</i> , that I last saw the deceased alive on <i>Oct. 11, 1956</i> , and that death occurred at <i>4 A</i> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>E Paul Knotts</i> M.D.		DATE SIGNED <i>Denton Md</i>	
PHYSICIAN'S NAME (Type) <i>E. Paul Knotts</i>		Denton, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-16-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hamletville</i>	22d. LOCATION (City, town, or county) (State) <i>Laurelville, N.J.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. H. Angel</i> ADDRESS <i>More Denton</i>		24a. REC'D BY REGISTRAR DATE <i>10/15/56</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. O. George</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3.

OCT. 19 1956

RECEIVED

10:59

CERTIFICATE OF DEATH

Reg. Dist. No.

66

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Florance Middle Emma Last Young				4. DATE OF DEATH Month 10 Day 1 Year 1956			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1885		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Soloman Hamond				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-3469		17. INFORMANT Ella Berry Ridgely, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive Hypertrophic				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1956 to June 21, 1956 , that I last saw the deceased alive on June 21, 1956 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles H. Winnacott M.D.				Ridgely, Md. 10-2-56			
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/56		22c. NAME OF CEMETERY OR CREMATORY Denton,		22d. LOCATION (City, town, or county) (State) Denton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouclair Greensboro, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 10/4/56		24b. REGISTRAR'S SIGNATURE Mary C. Laird	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

BUREAU V. S.

OCT 8 1956

RECEIVED